Calhoun Consultants



NEW PATIENT PACKET

(13 and Up)

Welcome to Calhoun Consultants.

Calhoun Consultants provides the highest quality of mental health care. Our goal is to assist with alleviating emotional pain and suffering for individuals, families and communities. Our plan for treatment is to improve each individual's quality of life.

We feel that your emotional health is a priority! Our plan is to provide services that are individualized for each and every client. Our clinicians will work with you to provide services that are comfortable for each individual while meeting their personal needs. It is important to us that you recognize improvement and obtain results in improving your quality of life.

Our team of clinicians is professional and well trained with scientific knowledge of useful treatment techniques. Such techniques can be used to assist individuals to cope with stressful situation in the home, work, school and community. Within treatment, we use traditional and complementary approaches with the highest level of clinical and ethical standards.

As a new patient, there are several things we will be asking for:

- Please fill out all forms completely.
- We will need a copy of your driver's license. (If you are writing checks for services rendered, we need this on file.)
- A copy of your current insurance card.
- Please verify that your physician/therapist is a member of your insurance plan. You can do that by calling your insurance company.
- Depending on whether you are here for medical or mental health reasons, your benefits might be different. Find out if you are required to pre-certify your visits. It might mean the difference in how, or if, your insurance company pays.

NEW PATIENT INFORMATION SHEET (13 and up)

Personal Information (must be filled out completely)

Doctor you are seeing today _____ Today's Date _____
Patient Name _____
Home Address _____
Street City State Zip

E-Mail Address _____
Home Telephone _____ Work Telephone _____
Cell Telephone _____ Other Telephone _____
Patient Date of Birth _____ Patient Social Security Number _____
Driver's License # of the Responsible Party _____
Employer _____
Employer's Address _____
Street City State Zip

Employer's Phone _____ Extension _____
Spouse's Name _____ Spouse Work phone _____
Referral Source (i.e.: Doctor, phone book, etc) _____
Referral Address _____
Street City State Zip
Referral Phone Number _____
Reason for coming to _____
_____
Family Physician _____ Telephone Number _____
Whom may we contact in an emergency? _____
Telephone number _____ Relationship _____

Insurance Information

PRIMARY Insurance _____
Group Number _____ Policy Number _____
Address _____
Street City State Zip

Insurance Telephone Number _____ Effective Date _____
Insured's Name _____ Insured's Date of Birth _____
Insured's Social Security Number _____
Employer's Name _____

Please note: Calhoun Consultants will only bill to secondary insurance if it is related to Medicare.

SECONDARY Insurance _____
Group Number _____ Policy Number _____
Address _____
Street City State Zip

Insurance Telephone Number _____ Effective Date _____
Insured's Name _____ Insured's Date of Birth _____
Insured's Social Security Number _____
Employer's Name _____

PATIENT INFORMATION

NOTE: ALL MENTAL HEALTH INFORMATION IS PRIVILEGDED AND HIGHLY CONFIDENTIAL.
The information you share is **STRICTLY BETWEEN YOU AND YOUR DOCTOR OR THERAPIST!** No information will ever be released without your written permission!

INSTRUCTIONS:
Please fill out this form completely. The answers to your questions are very important in allowing us to care for you. This form helps us care for you better. Some of these questions we ask may seem silly or that they don't apply to you. Regardless, answer all questions to the best of your ability.

Name: _____ Age: _____ Sex: ☐ Male ☐ Female Date: _____

What are the current problems that you are here for?

1. _____
2. _____
3. _____
4. _____
5. _____

PAST PSYCHIATRIC HISTORY

Have you ever seen a psychiatrist, psychologist or therapist in the past? ☐ Yes ☐ No

If yes, who? _____

Were you ever prescribed a medication to help your mood, anxiety, or thinking? ☐ Yes ☐ No If yes, what medications?

Which medications were helpful?

Have you ever had a bad reaction to medication? ☐ Yes ☐ No If yes, which ones?

Have you ever been hospitalized in a psychiatric facility? ☐ Yes ☐ No If yes, where and when?

Have you ever tried to take your life? ☐ Yes ☐ No

If yes, when and what did you attempt to do?

PAST MEDICAL HISTORY

Who is your primary care physician? _____

In the event that you request we contact your physician to coordinate your care, please give us your general doctor's phone number. _____

Do you have any medical problems? ☐ Yes ☐ No If yes, please list them:

1. _____

2. _____

3. _____

4. _____

5. _____

Have you had any surgeries? ☐ Yes ☐ No If yes, please list them with dates:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all medications with dosage that you currently take:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____

Do you have any allergies or sensitivities to medications? ☐ Yes ☐ No If yes, please list:

Have you ever been hospitalized other than for the above surgeries?

Have you ever seriously hit your head or lost consciousness?

Do you use alcohol? ☐ Yes ☐ No If yes, please answer the following questions:

What type of alcohol do you drink? _____

How many days per week do you drink? _____

How many drinks per day? _____

For how many years have you drank? _____

Do you use street drugs? ☐ Yes ☐ No If yes, please answer the following questions:

What different drugs do you use? (for each drug, please list how many days per week, and how many uses per day)

1. _____
2. _____
3. _____
4. _____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day? _____

How many years have you smoked? _____

FAMILY HISTORY

Does anyone in your family have any psychiatric problems? ☐ Yes ☐ No If yes, who and what type of psychiatric problems?

Does anyone in your family have any serious medical problems? ☐ Yes ☐ No If yes, who and what type of medical problems?

Does anyone in your family have a serious drug and/or alcohol problem? ☐ Yes ☐ No If yes, who and what type of drug or alcohol problem?

SOCIAL/DEVELOPMENTAL HISTORY

Have you been under a lot of stress lately? ☐ Yes ☐ No If yes, please list what events have been stressful.

Are you currently employed? ☐ Yes ☐ No If yes, where and what type of work do you do?

Are you: ☐ married ☐ single ☐ divorced ☐ widowed

Do you have children? ☐ Yes ☐ No

If yes, please list their names and ages:

1. _____ 4. _____
2. _____ 5. _____
3. _____

Have you suffered from physical, emotional, or sexual abuse? ☐ Yes ☐ No

Have you ever been in trouble with the law? ☐ Yes ☐ No If yes, please explain:

Have you ever served in a branch of the armed forces? ☐ Yes ☐ No If yes, what branch, when, and for how long:

Is there anything we did not ask that you feel is important or we should know?

GOALS

Many times people come to feel better or to manage a crisis. In addition, however, life enhancement is also something we may be able to help you with. For example: overcoming past painful events, improving self-esteem or self-understanding, losing weight, quitting smoking, improving your marriage, not worrying as much, improving self-confidence, dealing with sexual problems, changing the way you parent your children, etc.

What additional goals do you have that you would like to accomplish?

REVIEW OF SYMPTOMS

THE FOLLOWING IS A LIST OF SYMPTOMS THAT MAY OCCUR AS THE RESULT OF HIGH LEVELS OF STRESS OR BRAIN CHEMISTRY PROBLEMS. PLEASE CIRCLE YES OR NO TO THE FOLLOWING SYMPTOMS.

	YES	NO
Sad, blue or blah feelings	☐	☐
Low energy	☐	☐
Difficulty with concentration	☐	☐
Low motivation	☐	☐
Difficulty with memory	☐	☐
Change in appetite	☐	☐
Low self-esteem	☐	☐
Thoughts of not wanting to go on	☐	☐
Thoughts of ending your life	☐	☐
Plans to follow through on taking your life	☐	☐
Sense of loss of control	☐	☐
Waking up at night	☐	☐
Sleeping too much	☐	☐
Worrying a lot	☐	☐
Change in sexual interest	☐	☐
Feeling nervous	☐	☐
Difficulty controlling the worry	☐	☐
Low pep during the day	☐	☐
Changes in mood for no reason	☐	☐
Sense of hopelessness	☐	☐
Muscle tension in upper back and neck	☐	☐

PLEASE ANSWER THE FOLLOWING TO WHETHER YOU HAD A SUDDEN ONSET OF ANY OF THE FOLLOWING SYMPTOMS:

	YES	NO
Dizziness or unsteadiness	☐	☐
Upset stomach when nervous	☐	☐
Feelings of going out of your mind	☐	☐
Feelings of impending doom	☐	☐
Feelings like you might die	☐	☐
Feelings like you are out of your body	☐	☐
Feelings like things are not real	☐	☐
Shortness of breath	☐	☐
Pounding heart or chest pains	☐	☐
Onset of nervousness for no expected reason	☐	☐

SOMETIMES UNDER UNUSUAL STRESS, INDIVIDUALS MIGHT HAVE THOUGHTS THAT THEY ORDINARILY MIGHT NOT HAVE HAD. HAVE YOU EVER:

	YES	NO
Seriously hurt someone else	☐	☐
Heard a voice when no one was there	☐	☐
Thought others might be out to hurt you	☐	☐
Thought something which you were not sure was true or not	☐	☐
Noticed a change in your personality	☐	☐
Had weakness or numbness in any part of your body	☐	☐
Had new onset of headaches	☐	☐
Felt like you have to do something over and over again for no reason	☐	☐
Had a thought in your mind which you could not get out of your head	☐	☐
Do you have any problems with relationships?	☐	☐
Do you have any fears that interfere with your life?	☐	☐